STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155704	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 06/17/2014

NAME OF PROVIDER OR SUPPLIER **WALDRON HEALTH AND REHAB CENTER**	STREET ADDRESS, CITY, STATE, ZIP CODE **505 N MAIN ST** **WALDRON, IN 46182**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 5/14/14. Survey Date: June 17, 2014 Facility number: 000423 Provider number: 155704 AIM number: 100290450 Survey Team: Beth Walsh, RN-TC Tom Stauss, RN Census Bed Type: SNF/NF: 52 Total: 52 Census Payor Type: Medicare: 8 Medicaid: 37 Other: 7 Total: 52 Waldron Health and Rehab Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Recertification and State Licensure Survey.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE